

GENERAL QUESTIONS

Q: Will this and future PowerPoints be available after this call?

Yes, the PowerPoints are posted at
<http://www.dmas.virginia.gov/#/longtermprograms>
Choose the tab for Screening for LTSS.

Screening Connection is located under a banner near the bottom of the page. Slides and questions will be posted under Screening Connection.

Q: Will a hard copy of this training be made available?

A hard copy will not be sent to you but you can download if from the DMAS website.

Q: Is there a possibility for this monthly meeting to become solely electronic via documents? For example, for the powerpoint to be sent out monthly so that no one would have to worry with possible technical difficulties? And then Q&A's could be submitted.

We apologize for the continued technical difficulties. PowerPoints from the calls are available on the DMAS website for Long-Term Care and Q&A's will be made available. Questions can be submitted via the Conference Calls or to
ScreeningAssistance@dmas.virginia.gov

Q: Screeners have noted that it takes longer than 72 hours from ScreeningAssistance.

Yes responses from ScreeningAssistance may take longer depending on the depth of the question or the amount of research that is needed to resolve a problem. We are trying to respond as quickly as we are able and resolve in order of receipt.

Q. Is it possible to get a live person to talk with when you have questions about the **UAI (LTSS Screening?)** and the processes?

For specific questions, you can contact ScreeningAssistance@dmas.virginia.gov and request that someone call you back.

Please be patient. There are limited staff members and often calls last 30 – 60 minutes each. Staff cannot always respond with an immediate “live” call.

Staff in local departments of health may also reach out to Gavin Landry, RN,BS, the Pre Admissions Screening Program Manager at the VDH . Technical assistance may be requested through email, gavin.landry@vdh.virginia.gov or by phone (804) 864-7017.

PARTNERSHIP CONCERNS

Q: When the UAI was not filled out correctly and/or the DMAS-96 was checked “no” for [LTSS Authorization](#), in these cases, it is nearly impossible to get in contact with that hospital to correct the UAI. So do we just complete a new screening for the client?

It is the responsibility of the originating LTSS Screener to correct errors, resolve incompletes or denied status screenings.

If you cannot reach the originating Screener, you may contact Screening Assistance for further help.

Q: NF are saying that DSS won't come into facilities to do screenings. Who should they contact to do these screenings?

Nursing facilities are required to obtain copies of the Medicaid LTSS Screening PRIOR to admission.

Once someone is admitted to a nursing facility without a Medicaid LTSS Screening the community-based team will not complete a LTSS Screening for the individual to remain in the nursing facility. However, should someone who is a resident in a nursing facility not have a screening due to one of the Special Circumstances, and this individual wishes to leave the NF and use CCC Plus waiver or PACE, the community-based team may enter the NF to complete the Screening so the individual may enroll for home and community based services.

WORKING WITH HEALTH PLANS

Q: Is there a way to find out exactly who the Care Coordinator is to ask ongoing questions after a screening?

The DMAS LTSS Screening Unit does not have a listing of all health plan care coordinators. If the individual does not know who their Health Plan Care Coordinator is and you need to know a name in order to discuss a case, you may try contacting the DMAS Division of Integrated Care at CCCPlus@dm.virginia.gov

In order to provide a general referral and copy of the LTSS Screening package, all screeners should use the list of phone number provided in the Medicaid LTSS Screening Manual and on-line training.

WORKING WITH NURSING FACILITIES

Q. Do we have to type up our own forms for the exclusions that are to be sent to the nursing home if a patient does not meet criteria for a UAI?

Screening Teams do not necessarily have to type anything up OR create their own forms, but DMAS encourages the sharing of appropriate information between hospital, community-based team and NF.

Screening teams should be familiar with the Special Circumstances as to when a Medicaid LTSS Screening is not required and provide the rationale to a NF during the admission process. NFs and MCOs utilize the DMAS-80 for documentation of Special Circumstances and screening teams are allowed to co-opt the form to aid in communication with others. Screening Teams are also encouraged to document special circumstances in any electronic health record maintained for the individual.

COPIES OF SCREENINGS

Q: IS there a way to be able to print off a patient's Screening when completed somewhere else? Will the system ever allow for that to occur as it is quite a challenge to obtain a completed screening from providers?

Currently, a LTSS Screeners from one facility/locality cannot view nor print a LTSS Screening conducted by another facility/locality. This is due to the protected health information that is collected.

ScreeningAssistance does not know if this will become an option in the future.

Q: If so, are providers, MCOs or individuals able to obtain a copy of this screening without calling the CBT's or hospital?

No. LTSS Screeners are to provide a copy of the LTSS Screening package to providers, health plans and to the individual. All LTSS Screening entities are to be able to provide copies of LTSS Screenings for at least six years (for adults) and for children six years past the individual's 21 birthday.

This requirement does allow that the LTSS Screener enter the ePAS system and print a copy of the screening packet as necessary from ePAS. However, remember that ePAS has not been existence for six years; thus, the older hardcopy files must still be available and accessible.

Q: If so, are they able to obtain a copy of this screening without calling the CBT's?

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Q: We are often asked by providers to perform a UAI (LTSS Screening) that has been completed by the hospital. We need access to the hospital UAI to prevent duplication. How do we get access?

You may contact Screening Assistance to request a copy of a LTSS Screening packet. When requesting packets Screening Assistance needs the individual's name and SSN, and if available the Medicaid number.

PHYSICIANS

Q: What is the role of the physician and what training do they need to take starting in February? We have too many MD/DO to go through training.

It is part of the Code of Virginia and Virginia regulations that ALL persons who sign the Medicaid LTSS Screening Authorization (DMAS-96) must be certified.

Physicians (or nurse practitioner or physicians' assistant) must review the LTSS Screening documentation and be the LAST person signing authorization or denial of long-term services and supports.

As the physician signs the LTSS Screening, the physician is reviewing the documentation and determining whether the information:

- Fits the physician's clinical impressions and assessment of family supports.
- Accurately portrays the individual's care needs. And
- Addresses the three components for determining the need for Medicaid LTSS. i.e. functional abilities, medical/nursing needs and as well as being "at risk" for nursing facility or hospital readmission within 30 days or less.

Review the Screening with involved staff as needed and correct any discrepancies, note any additional needs.

Q: Does a physician have to complete this training in order to sign as a Level 1 physician?

Yes

Q: Does DMAS notify the physicians of the required LTSS screening training or do the hospital screeners inform them?

Both. A Medicaid Bulletin will be issued soon. However, the training portal is open and physicians can take the training at any time.

Q: Will doctors have to log in for each screening after they complete the module 5?

Doctors must log into ePAS to attest to their signature. This is the law currently. During the summer of 2020 physicians must begin inserting their certification number as well as attest that they've reviewed the screening and concur with the determination made.

Q: If doctor has already completed the original LTSS training and was certified - do they still need to do Module 5?

No. The existing certification is good for three years.

SIGNATORY AUTHORITY

Q: Just to confirm that the LTSS Screening can be signed off by a Nurse Practitioner (NP) and Physician's Assistance (PA) who are working under an MD at the hospital?

Yes. A NP or PA working with a physician in a hospital or local health department may sign the DMAS-96. Remember beginning June 1, 2020, that individual must have completed at least Module 5, Physicians' Module of the Medicaid LTSS Screening training.

Q: Do physicians have to cosign NP and PA signatures?

No.

Q: Will doctors/PA/NP have to log in to sign off for each screening after they complete the Module 5?

All signatories **MUST** sign in and attest to their name and the statement. This is the current law. The only thing new is that beginning June 1, all physicians (or those signing for the physician) must be certified and insert their certification number.

Please note the signature area states the following:

“By checking this box and entering your name as the Physician below, you attest that this authorization **[this means the authorization of Medicaid LTSS]** is appropriate to adequately meet the individual’s needs and assures that all other resources have been explored prior to Medicaid authorization for this member. Any person who knowingly submits this form containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.”

HOSPITAL SPECIFIC Q&As

Q: Can you speak more to the 3-day post discharge rule?

This issue is now a moot point. There is no longer a 3-day post discharge rule.

Q: Were hospitals included in the decision to remove the "3 day allowance" from the law? We are struggling to get screenings done due to high volumes, have capacity issues, and SNF refusing to accept patients until screening is completed. Hard to keep up.

The decision to retract the 3-day allowance was necessary to assure adherence to federal laws and assurance of completion of screening PRIOR to NF admission.

Q: Can hospitals complete a DMAS-96 without doing a LTSS screening?

Absolutely not. In order for someone to be authorized for LTSS the full Medicaid LTSS Screening must be completed.

Q: If facilities refuse to take a patient without a level 1 being completed by the hospital, is there anything that the hospital can do? This is for patients that will not qualify for Medicaid

No, there is nothing the hospital can do. A level 1 Screening is really a screening for mental illness (MI), intellectual disability (ID) and related conditions. EVERY individual who seeks admission to a Medicaid-certified facility **MUST** be screened for MI, ID or related conditions. The individual’s financial status is **NOT** a factor. It is the status of the nursing facility.

For individuals who are private pay or would not have a Medicaid LTSS Screening due to one of the Special Circumstances, it is incumbent on the nursing facility to have a process for obtaining a PASRR Level I Screening (and if needed, Level II evaluation and determination) PRIOR to NF admission.

Q: If a hospital authorizes NF with "temporary" length of stay - for a client being discharged to a rehab center, and later the client goes home from rehab can Waiver services then continue or no? Would they need a new screening?

There is no need for another LTSS Screening. The long term services and supports screening is about assessing someone's level of care for the LONG TERM – not a temporary length of stay. Hospital staff should determine to the best of their ability if someone meets the level of care criteria for ongoing LTSS. If the hospital authorizes Medicaid LTSS then that authorization is good for nursing facility services, CCC Plus waiver or PACE. An individual may move from NF to CCC Plus waiver.

COMMUNITY-BASED SCREENING TEAM SPECIFIC QUESTIONS

Q: If you do a screening but unable to complete within the 30 days because you simply could not get the medical records you needed, does that count as a late screening. If you have made your visit with client but did not submit due to needing info

Yes, it would be reflected as a late LTSS Screening. The computer system tracking submissions uses the request date and submission date to track the 30 day requirement for Community-Based teams to complete Screenings. If you are having problems please contact Gavin Landry who is the VDH PAS Manager for assistance and guidance.

SYSTEM ISSUES

Q: What is a DMAS-P98? Does this reference a page number? Or is it the name of a form?

The DMAS P98 form is described in your LTSS Screening Training. There are two ways that screening data and collected information can be entered into ePAS - directly by manual data entry into the online e-forms in the portal or by entering data into a downloaded DMAS-P98 form and then uploading that form. The DMAS-P98 form was designed for screeners to use in the field, store on a computer and later upload into ePAS. The DMAS-P98 form should be downloaded from the Medicaid portal each time it is used to ensure that all fields are clear and data entered corresponds to the individual being screened. The DMAS-P98 form downloads as an Excel file with each tab at the bottom corresponding to a DMAS Screening form. The DMAS-P98 form includes all of the forms used in the Screening Process. When ready to upload a DMAS-P98 form, the Screener will enter the ePAS portal and choose to upload the form. Should

you need to make revision in the Screening information, once a DMASP-98 form is uploaded, you will need to recall the Screening and make changes directly in the portal. Do not make changes in the DMAS-P98 which may still reside on your computer and re-upload – this action will create a duplicate record. To the extent feasible, the best practice for working offline is to complete as much of the DMAS-P98 form as possible prior to uploading to portal. The remainder of the data may be entered online. Please note: The electronic form and DMAS-P98 form does not list the categories for dependent, semi dependent, or independent. Screeners should use the LTSS Screening Manual Chapter IV for reference to ensure accurate determinations are made.

Q: We can see if it was successfully processed in epas, but not whether or not the screening was authorized.

The electronic submission portal does NOT authorize individuals. The LTSS Screener must review the information in the Screening, compare it to the level of care criteria for Medicaid LTSS and make a determination of authorized or not. The computer system does not do this.

Q. IS there a way to be able to print off a patient's Screening when completed somewhere else? Will the system ever allow for that to occur as it is quite a challenge to obtain a completed screening from providers?

Currently, a LTSS Screeners from one facility/locality cannot view a LTSS Screening conducted by another facility/locality. This is due to the protected health information that is collected.

ScreeningAssistance does not know if this will become an option in the future.

Q: Why not allow the managed care providers and FFS providers' access to pull the screenings from MMIS? This would solve the issue of printing and sending multiple copies of the screening. If the individual has a copy, they should be able to send it to a new provider.

Different providers and health plans have different levels of access to MMIS. Currently, rules around protected health information prevent unilateral access to health records.

The LTSS Screenings are entered into a separate portal that "talks" to MMIS. Access cannot be provided to ePAS due to issues of data sharing, fraud, and protected health information. This may be something that is addressed in the future if safety controls and fraud abuse management tools are incorporated into the electronic systems.

Q: Confirming that on slide #8, NH's Health Plans and providers can look into the ePAS system or another system to see if a screening has been done?

No, health plans, other providers and NFs cannot enter ePAS and review a LTSS Screening. However, once an individual chooses their care, when the provider or health plan attempts to enroll the person into the system, the computer will check against the file of LTSS Screenings and authorizations to determine if a valid, authorized screening exists.

Q. Why does it (ePAS) time you out, and then you have to start completely over?

The computer program was designed to time out after 30 minutes.

Q. Will ePAS be updated soon to reflect choices of CCC+ Waiver (instead of EDCD terminology)?

Yes. It is very expensive to change computer systems. Because DMAS is aware of a systemic change which will affect ALL of DMAS portals. A decision was made not to make updates in the current system and incorporate all updates in to the new system.

Q: If we've checked and the names are wrong or does not match on their Medicaid ID, SSN card, or even their ID, what information or identification should we rely on?

You should review the types of allowable documentation used by Cover VA.
<https://www.coverva.org/materials/Verification%20Documents.pdf>

A birth certificate would be a key item.

Q: If it is not an auto filled problem do we still have to have DSS make the correction?

Q. What types of information do you need to make the corrections when the information is not correct?

If there is an autofill error you must contact ScreeningAssistance@dmass.virginia.gov providing the name, SSN, and Medicaid number (when available) and explain the auto-fill problem. ONLY DMAS eligibility staff are allowed to make changes to correct an auto-fill error. Do not contact local DSS for auto-fill error problems. Local DSS staff are not authorized to make this type of correction.

If a LTSS Screener makes an error in the screening information but submits the screening for processing, the LTSS Screener must contact ScreeningAssistance@dmass.virginia.gov providing the name, SSN, and Medicaid number and explain the error or problem.

FREQUENTLY ASKED QUESTIONS: SCREENING CONNECTION CALLS

Medicaid LTSS Screening Assistance

Updated 4.1.2020

DMAS Screening Assistance staff requests that all Screeners triple check work prior to submitting a screening for processing. Based on the type of error, it takes at least 72 hours for correction and sometimes longer.

Q: The Suffolk health department (HD) uses 2 nurses to do pediatric clients and no local DSS is involved. On the DMAS-96 there are two spaces for the level I screeners to place their ID #'s. Should we be repeating the ID # for each nurse involved with the screening?

The top half of the DMAS-96 form provides a location for provider numbers. Even if the local DSS did not send a staff member to the screening, a provider number for the local DSS must be entered in this section. If provider numbers for VDH and LDSS are not entered, the screening will not process.

Two people may sign, enter certification number, date and attest to the information. These two people are be two VDH screeners or a VDH and a DSS screener.

Q: What do you do if you forgot to complete the DMAS-97? Do you need to have it voided and re-entered? If so, why is it being listed as successfully processed without information on the DMAS-97?

The current LTSS electronic screening system (ePAS) does not have an edit that stops the processing of the entire Screening. However, the information should be entered into the system so that the printout has all of the information collected during the LTSS Screening Process.

Q: We are currently having issues with when we submit any screening after 4 pm (EST) they will not process until the next day after 5 pm (EST) which causes a delay when trying to discharge patients from the hospital. Do you know if this will get fixed?

This will be fixed in the new screening electronic submission portal. The submissions are supposed to be processed (or denied if there is an error) at the time of submission.

Q: This is also happening on the weekend as well.

This will be fixed in the new screening electronic submission portal. The submissions are supposed to be processed (or denied if there is an error) at the time of submission.

Q: If we can't find a SSN for a patient, and the "fake" one has already been used by a different patient, what do we do?

As described in Module 3 of the Medicaid LTSS Screening training, you must continue to cycle through the alternate Default SSN sequence process.

There is only one DMAS approved method for establishing a default social security number. This method uses a default sequence which is the individual's date of birth. Starting with 000, the screener then uses the two digit Month, Day, and Year of the individual's birth date to create a nine digit number **000-MM-DDYY**.

Because more than one person can have the same birthdate, you may encounter a problem entering a default social security number. If this happens an **alternate default sequence must** be used.

To create an **Alternate Default Social Security number Sequence** first try increasing the day digit by one in the date of birth sequence. Please note you should not change or make the actual Date of Birth in the demographics section match the alternate default social security number sequence.

If you are still unable to enter the alternate default social security number sequence, you must continue to increase the birth day by one until you find a number that is not being used. Sometimes this may also include moving to the month place if needed.

Do Not Create Your Own "placeholder" or alternate pseudo Social Security or Medicaid ID number. Sequences such as 999999999, 333333333, 123456789, or others often have specific technology meaning and will cause record retention problems and/or create an erroneous claim or link records to the incorrect individual.

Please make a note in the clients chart and on the UAI notes section that the alternate method was used.

Q: If there is a child with a pseudo SSN, and the child is discharged from the hospital prior an actual SSN being provided, do we need to re-upload the LTSS Screening with the real/actual SSN into ePAS? Do we need to contact screening assistance in order to delete the old one?

Yes, for any LTSS Screenings that have been "successfully processed" and have an error or need a correction/update, a void **MUST** be conducted.

It is essential that information on the LTSS Screening is correct, especially Name, SSN, Medicaid ID and gender. If this information is not correct, the individual may not have records linked and could be denied services now or in the future.

Conducting LTSS Screenings on babies can sometimes be challenging. The ePAS portal in conjunction with the VAMMIS and other DMAS portals have been designed to have checks and balances. The checks and balances are dependent upon the screening being attached to the correct Social Security Number and/or Medicaid number. The following are some tips to assure that this occurs appropriately for babies awaiting a Social Security Number:

- The legal representatives should be asked if a Medicaid ID number has already been established/provided for the baby (not the mother's Medicaid ID but the baby), if there is one, the screener can contact Screening Assistance to research for a default SSN which may already be in use in the Medicaid system for the baby. If there is not a Medicaid ID, the screener will need to use a pseudo-SSN or default-SSN (DOB sequence 000-DOB MMDDYY) which will generate a one day Medicaid ID number. It is important that the legal guardians know and share the Medicaid ID number (that the screening team created), with the local DSS Eligibility staff. By sharing the one-day Medicaid ID the creation of separate or duplicate numbers can be avoided, as well as reducing the risk of multiple records being created in VAMMIS. If the provider or health plan will not accept the default-SSN, then the LTSS screening will have to be voided and corrected later once an actual SSN has been issued.
- The DSS eligibility staff will have a process for updating the demographics once the baby's name is established. It will be important to share this information systematically with the family so that the screenings are attached appropriately to the baby's record.

Q: If a person dies after the screening is successfully processed, and doesn't get services, what should you do?

LTSS Screeners do not need to do anything. The local DSS eligibility unit will handle changes in the status of the individual.

Q: Should the **DMAS-97** be entered into ePAS for all screenings or just the screenings that are going to pass for services?

The **DMAS-97 Individual Choice Form** is a required form in the LTSS Screening packet for ALL screenings conducted (whether they meet criteria or not). This form also serves the purpose to document that you obtained permission from the individual or individual's representative to conduct the screening and that you informed the individual of their appeal rights. Required forms are listed in the LTSS Screening Manual and in the LTSS Screening Training.

Q: Screeners are having difficulty entering height and weight of small children - won't let them enter heights less than 24" and weights less than 10 lbs. Could this be fixed?

DMAS reviewed this and could not duplicate this problem. Heights and weight must be entered as whole numbers but 1 pound and 1 inch was accepted by the computer system.

FREQUENTLY ASKED QUESTIONS: SCREENING CONNECTION CALLS

Medicaid LTSS ScreeningAssistance

Updated 4.1.2020

The next time you have this problem please send a screen shot of the error to
ScreeningAssistance@dmass.virginia.gov

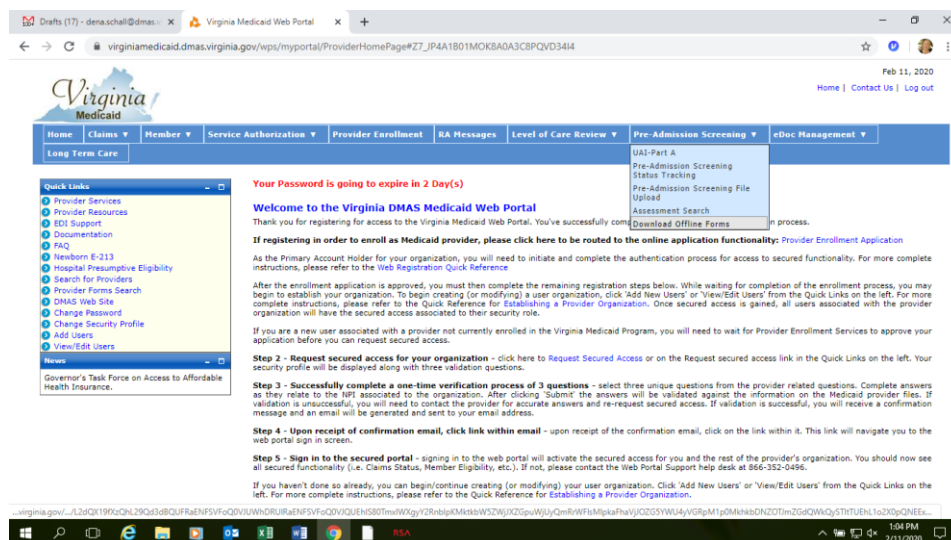
Q: Several of us at VCUHS have experienced our work not saving. What can be done to prevent this?

Q: ePAS has been freezing and we are having to start over

DMAS has discussed these issues with the ePAS developer. DMAS suggests the following:

- ePAS will time out periodically, so it is important to save frequently so that they don't lose data entry
- Bandwidth or connectivity issues at your facility could kick you off mid-entry at anytime
- Make sure to turn your computer off periodically. Leaving your computer on all the time can eventually result in systems not working correctly.
- It is strongly suggested that if you continue to have ongoing issues that you consider using the P98-Upload feature in ePAS.

[SEE screen shot below] On the ePAS tab-drop down, you will see two things: A. Pre-Admission Screening File Upload and B. Download Offline Forms. B. is where you would download the P-98 Form which is an excel workbook that has all of the forms tabbed at the bottom. You can enter all of the screening information and save the form to the computer until ready for upload. A. is where you upload the P-98 into ePAS. Once uploaded, you will need to check over the screening forms for accuracy and then submit. Additional information about this process is in the LTSS Electronic Screening Training.



SEARCH FEATURES

Q: How does a Screener search to determine if another LTSS Screening exists?

ePAS-Assessment Search feature

Once logged into ePAS, go to the Pre-Admission Screening tab and select **Assessment Search** on the drop down list.

Type in the individual's social security number in the "Previous Assessment Search" box.

If there is any information to be shown from the Medicaid Management Information System (known as MMIS or VAMMIS), the system will show the most recent information. Keep in mind that a status of "Successfully Processed", DOES NOT necessarily mean that the screening was authorized for NF level of care. It means that a screening was processed and the screening team was paid. You will need to contact the Hospital or Community Based Team and ask for a copy of the Screening to determine if the individual was authorized for LTSS.

Approved Screenings remain active unless the individual is terminated from services. When there is a termination the individual must apply for Medicaid LTSS again via a new screening.

The screenshot displays the Virginia Medicaid Web Portal interface. The browser address bar shows the URL: https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderHomePage#Z7_JP4A1B. The portal header includes the Virginia Medicaid logo and navigation links: Home, Contact Us, Log out. A main navigation bar contains tabs: Home, Claims, Member, Service Authorization, Payment History, Provider Maintenance, Provider Enrollment, RA Messages, and Level of Care Review. Below this, a sub-navigation bar includes: Pre-Admission Screening, eDoc Management, Provider Portal Secure Email, and Long Term Care. The left sidebar menu is expanded to show the 'Assessment Search' option under the 'Pre-Admission Screening' tab. Other menu items include: UAI-Part A, Pre-Admission Screening Status Tracking, Pre-Admission Screening File Upload, Download Offline Forms, Newborn E-213, Hospital Presumptive Eligibility, Search for Providers, Provider Forms Search, DMAS Web Site, Change Password, Change Security Profile, Add Users, and View/Edit Users. The main content area displays a 'Welcome to the Virginia DMAS Medicaid Web Portal' message, followed by instructions for registration and enrollment. It includes a 'PPM EFT Notice' and a 'News' section. The bottom of the page shows the URL: https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ut/p/z/04_S9CPYkssy0pPLMnMz0vMAFjo8zivQJHMA2dDA... and the system clock shows 4:10 PM on 3/9/2020.

MEDICAID ENTERPRISE SYSTEM (MES) AND NEW PORTALS

Q: When will the “new” computer system DMAS is developing be available?

Work is continuing on the “new” system calls Medicaid Enterprise System (MES). The finalization date is currently uncertain due to the impact of COVID-19 but projections have it completed at the end of 2020.

Q: Can we give feedback on the new portal before it is finalized?

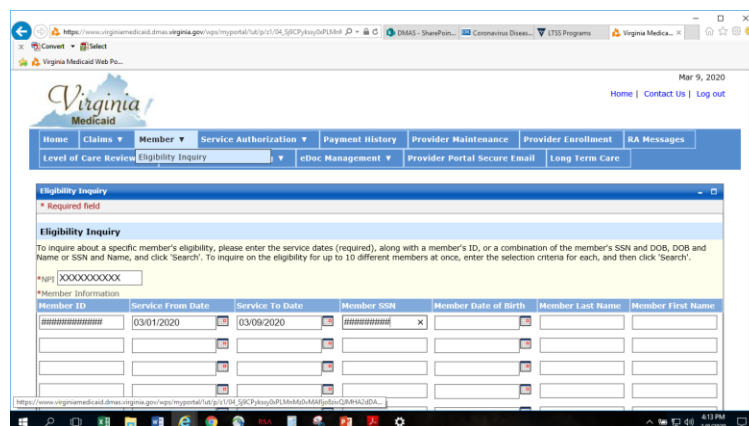
The new electronic screening portal will be tested by a group of LTSS Screeners. If you are interested in being in the testing group, please send your contact information to ScreeningAssistance@dm.virginia.gov. Currently Screening staff does not know when testing will occur or how many people will be included in the test group.

VERIFYING A PREVIOUS AUTHORIZATION FOR SERVICES

Q: How can a Screener see if services were authorized for a patient without having to request the screening?

ePAS Member Eligibility Search Feature

Once logging to ePAS go under the tab Member and select Eligibility Inquiry. Enter in your NPI, the individual’s Medicaid ID or SSN (do not use name as names are often misspelled), the date range for the **current month** and then search. Information should display at the bottom of the screen. If the person is in a MCO the name should display and if the person is currently in the CCC Plus Waiver, the name displays as “AGED”. If you see AGED display then a screening is not needed and the individual needs to be connected with their MCO Care Coordinator or provider to help the individual resume Medicaid LTSS Services.



| Member ID | Service From Date | Service To Date | Member SSN | Member Date of Birth | Member Last Name | Member First Name |
|------------|-------------------|-----------------|------------|----------------------|------------------|-------------------|
| 03/01/2020 | 03/09/2020 | XXXXXXX | X | | | |

HANDLING VOIDS

Q: Can we re-enter a screening while we wait for a void to occur?

It depends on the scenario or error that has occurred.

Any screener can re-enter/type in a whole new screening while waiting for a void but it may not be necessary or efficient, and depending on the error, the Screener may receive an ePAS error message stating that a screening has already been conducted for that person and date.

For most errors involving wrong auto-fills for the Social Security Number or Medicaid ID Number, the LTSS Screening will have to be re-entered using the "new UAI button". In these cases a screener can start re-entering the information using the CORRECT social and Medicaid ID.

In all other situations we recommend that the void occur first, when the void converts to incomplete in the tracking status, use the "recall" button to initiate a new screening. The recalled screening will auto populate with all of the former information. Screeners can then correct any mistakes/errors, and resubmit. Using the recall feature usually saves time because everything does not need to be retyped.

Q: We can't send that info in an email to void because it wouldn't be encrypted.

Please work with your local IT department to establish encryption procedures.

ScreeningAssistance will be happy to respond to any request with an encrypted email. Often the encryption is maintained for responses back and forth between an outside agency and DMAS.

WHAT DOES "DENIED" REALLY MEAN?

Q: Patient requests a LTSS Screening even though he does not meet criteria for care needs. Form is submitted and returned as "Denied". This does not show up on the Printed document. Should this copy still be given to the patient?

There are several issues to address in this question.

- 1) Medicaid is an entitlement program – services are provided through the use of Federal and State tax payer dollars; thus, every individual in the Commonwealth has the option to apply for services. Every person who requests a LTSS Screening, must be Screened.
- 2) If you receive notification of a LTSS Screening being “Denied” it does not mean the Medicaid Authorization is denied.

The words "Successfully Processed", "Denied" or “Submitted for Processing” which are located on a copy of the LTSS Screening and in the computer system does NOT relate to Medicaid Authorization of LTSS eligibility. These words only relate as to whether the computer system accepted the Screening information.

- 3) All persons screened should receive a copy of their LTSS Screening results and MUST receive a letter indicating approval or denial of authorization for services. Denial letters MUST include appeal rights for the individual.

ISSUES INVOLVING CHOICE

Q: What about a safe plan of care? An individual wants personal care but that is not appropriate due to safety concerns?

With the shift to managed long term services and supports, 90% of Medicaid members are enrolled in a health plan. It is the responsibility of the assigned health plan Care Coordinator to work with the individual and their family to develop an appropriate, person-centered plan of care – including assurance of health, safety and welfare. If the setting appears to be unsafe or compromises the individual’s welfare, then the Care Coordinator must work with the individual and provider network to ensure the appropriate services are implemented to best assure the safety of the individual. If the individual refuses recommended services, the Care Coordinator should consider continued NF coverage or consult with APS as needed.

If a LTSS Screener disagrees with the plan of care developed by the health plan Care Coordinator, the Screener should voice concerns directly to the Care Coordinator to ensure identified risks are addressed. Collaboration with the Care Coordinator or treating providers is encouraged. Information from the Screener would be helpful in completing a comprehensive plan of care with backup and safety plans in place. A LTSS Screener should not alter an individual’s choice of setting and services unless there is a documented reason which should be noted in the Case Summary.

Please remember that it is paramount that individual's choice is honored. Medicaid members did not have care coordinators in the past. Most of the individuals being screened for LTSS are going to be members of the CCC Plus program. This means the care coordinator is required to work with the individual to assure a safe plan of care and that all safety, health and welfare concerns are addressed.

If you determine someone cannot participate in the CCC Plus waiver or PACE due to health, safety or welfare concerns, these issues should be WELL-DOCUMENTED and noted in the case summary of the UAI. We further recommend that you speak with the health plan care coordinator or PACE facility to share your concerns.

Q: What happens if someone changes their mind from CCC+ to NH after the screening has been processed?

This is allowed. Individuals MUST have options of choice of settings (NF or community) and providers. Individuals are to be allowed to change their decision at any point in the process, even if services have started. LTSS Screeners are documenting the choice made at the time of the LTSS Screening. If an individual changes their mind, the health plan care coordinator or FFS provider MUST provide assistance and enable the individual to realize their choice of settings and provider, unless there is a well-documented health, safety or welfare concern.

Q: Also what do you put on the DMAS-96 if the plan switches from NF to consumer directed and vice versa?

There is no problem as long as the individual was authorized for long-term services and supports (LTSS). LTSS Screeners do not need to "correct" anything. DMAS allows changes to the chosen setting and provider. If an individual is considered competent, the individual's CHOICE is to be respected. Except in extreme circumstances and in those circumstances APS should be consulted.

It is the responsibility of the assigned health plan care coordinator to work with the individual to develop an appropriate, person-centered plan of care – including assurance of health, safety and welfare. If the setting appears to be unsafe or compromises the individual's welfare, then the Care Coordinator must work with the individual to assure safety and if the individual refuses, APS must be contacted.

A LTSS Screener should not alter an individual's choice of setting and services unless the person has been deemed incompetent or there is a documented reason which should be mentioned in the Case Summary. If you are concerned regarding services chosen or a change in services, you can certainly contact the Care Coordinator or Provider and share your reasons for concern.

Q: What do we do if the plan changes from NF to CCC Plus Waiver or vice versa, after the screening has been successfully processed?

Individuals are to be allowed to change their decision at any point in the process, even if services have started. By Federal Medicaid laws individuals MUST have options of choice of settings (NF or community) and providers. LTSS Screeners are documenting the choice made at the time of the LTSS Screening. If an individual changes their mind, the health plan care coordinator or FFS provider MUST provide assistance and enable the individual to realize their choice of settings and provider, unless there is a well-documented health, safety or welfare concern.

Q: What if the patient/family changes their mind about location of the service after the screening has been successfully processed.

There is no problem as long as the individual was authorized for long-term services and supports (LTSS). LTSS Screeners do not need to “correct” anything. DMAS allows changes to the chosen setting and provider. If an individual is considered competent, the individual’s CHOICE is to be respected. Except in extreme circumstances and in those circumstances APS should be consulted.

Q: What do we put on the paperwork?

There is no need to change information in the Screening.

Q: If a client chooses Home Services but it is not a safe plan can the CBT authorize NH instead? Or just write in notes it is not recommended.

Please remember that it is paramount that individual choice is honored. Medicaid members did not have care coordinators in the past. Most of the individuals being screened for LTSS are going to be members of the CCC Plus program. This means the care coordinator is required to work with the individual to assure a safe plan of care and that all safety, health and welfare concerns are addressed.

If you determine someone cannot participate in the CCC Plus waiver or PACE due to health, safety or welfare concerns, these issues should be WELL-DOCUMENTED and noted in the case summary of the UAI.

Q: As far as CHOICE and the DMAS-97 and DMAS-96 - sometimes a client's choice is CCC+ Waiver so that is what we put on the DMAS-97 but there is no safe plan so screening team is only able to authorize NF. Choice & authorization may be different.

This is true but be very careful in negating an individual's choice of settings and services. Please also remember, it is the role of the care coordinator to also assure health, safety and welfare.

MEDICAID AUTHORIZATION CODE IS INVALID IN CROSS EDIT VALIDATION

Q: What does MEDICAID AUTHORIZATION CODE IS INVALID IN CROSS EDIT VALIDATION mean?

This is discussed in the Medicaid LTSS Screening Training and is listed on the MMIS and ePAS Denial reference Sheet.

This means that the authorization decision on the DMAS-96 is not supported by the information provided in the UAI. LTSS Screeners should review the worksheets to determine need for Medicaid LTSS to identify what is inconsistent.

Please note that an authorization for LTSS must be supported by all of the following:

- Meeting one of the Categories for functional needs.
- Ongoing medical or nursing need.
- At Risk for institutionalization (hospital or NF) within 30 days if the person does not receive services and/or supports.

Q. Where are the worksheets for determining authorization for services located?

Every LTSS Screener should be using utilizing the [Worksheets for Determining the Need for Medicaid LTSS](#). Use of these worksheets will reduce the number of cross-validation errors a screener may encounter.

The worksheet resource is located at the end of the Medicaid LTSS Screening Manual, Attachment B. [MMIS Medicaid Portal, select Provider Services tab and then select Provider Manuals from the drop down list. Select Provider Manuals once again and under accessing provider manuals use the drop down list and select Pre-Admission Screening or LTSS Screening and submit].

The worksheets are also discussed and provided as a handout in the Medicaid LTSS Screening training, Module 2C.

DOCUMENTATION

Q: Can you speak to the authorization letters from the inpatient hospital screener. Saving the letters, do we need to keep a hard copy of the letters.

We recommend having a hard copy or scanned copy of the letter to document that you followed the procedures for LTSS Screening and provided appeal rights to those who are not authorized for LTSS.

Q: Do we need to keep a hard copy of the letter sent to the patient with the DMAS-97

It is best practice to retain a copy/scanned copy for the record.

Q. Can you speak to the Accept/Denial letters, time parameters, etc.

Letters should be sent as soon as possible. An individual only has 30 days from the date of screening to submit for an appeal of the determination decision .

RECORD RETENTION

Q: When we use the ePAS system to retain the record for required time frame, are we required to keep the DMAS-97 and Release of Information form the patient signed?

Yes, you must still retain the signed copy of the DMAS-97 in the individual's record.

PASRR

Q: What do we do when there will be no DMAS-95. Some NFs will not accept a client without the DMAS-95, even though we tell them it's interchangeable.

The DMAS LTSS Screening and the DMAS-95 are NOT interchangeable. The DMAS-95 Screens for potential existence of mental illness, intellectual disability and related conditions.

The Medicaid LTSS Screening determines multiple things.

- 1) Using the UAI, an individual's Level of Care is determined. If someone wishes to use services in the CCC Plus Waiver, PACE or a nursing facility, these three options have the SAME level of care criteria and are interchangeable.
- 2) As a matter of convenience, the Medicaid LTSS Screening also includes a screening for POTENTIAL mental illness (MI), intellectual disability (ID) and related conditions. EVERY person being admitted to a Medicaid-certified nursing facility MUST be screened for MI, ID and related conditions and if any of these are found, the individual must be evaluated and a determination made as to whether specialty

services are needed and whether those services should be offered in a NF or in the community.

To document this information, the DMAS-95 and supplement are used.

- 3) The Medicaid LTSS Screening in its entirety is NOT interchangeable between NF, CCC Plus Waiver and PACE, only the Level of Care is interchangeable. Any admission to a Medicaid-certified NF requires a MI, ID and related conditions screening, just as for any admission to PACE an individual must be 55 years or older. Each of the three types of services may have unique conditions which must also be met in order for enrollment to occur.

Q: When someone who has community services decides to move to a NF, often a DMAS-95 (also known as a level I screening) does not exist. Who is responsible for the screening for MI, ID and related conditions?

Related questions

Q: Please elaborate on the Level 1 screening for those who have been screened in the past and have been receiving services for months or longer. How is that to be done? The screener may not know the individual and the person may have new diagnoses since then.

Q: If someone has CCCP waiver and wants to change to NF, then who completes the PASRR. In the last guidance, it was noted that the NF can complete the the Level II.

The NF is responsible for conducting the PASRR **process** (Level I and II if warranted) before any NF admission. If the CCC Plus Waiver or PACE is initially chosen by the individual and authorized/successfully processed by the screening team but later the individual chooses to transition to a NF, the screening is transferrable (meaning there is no need to determine if someone meets the level of care required for NF services), but the NF **MUST** assure completion of the Level I screening and if needed Level II evaluation and determination.

PLEASE NOTE: A NF is allowed to complete the Level I Screening, using the form developed by DMAS and posted on the webpage:

<http://www.dmas.virginia.gov/#/longtermprograms>

Level I Screening for Mental Illness, Intellectual Disability, or Related Conditions Form [pdf]

Should the NF find that the individual has the potential to be living with mental illness, intellectual disability or a related condition a Level II evaluation and determination **MUST BE REQUESTED**. This request is sent to Ascend, NO NF may complete the Level II. NFs can **ONLY**

refer for a Level II. Both Level I and if needed, Level II, must be completed PRIOR to NF admission

Q: I'm a hospital screener. Skilled nursing facilities often ask for the DMAS-95 alone for by when patient not going long term. Only rehab. Is this request a valid practice? My understanding is that DMAS-95 is only for long term care and is part of the UAI.

All individuals entering a nursing facility MUST be screened for the potential of living with a mental illness, intellectual disability or related condition (often developmental disability). This requirement is federal and applies regardless of payer source or type of service to be received in the NF.

For individuals who are inpatients at a hospital and are Medicaid members or likely to be Medicaid members, the process is handled as part of the LTSS Screening and screeners use the DMAS-95 to document the results.

For anyone who does NOT received a LTSS Screening, the NF must assure the completion of a Screening for MI, ID and related conditions. DMAS has a form on-line for the NFs to use. It is located at: <http://www.dmas.virginia.gov/#/longtermprograms> - Level I Screening For Mental Illness, Intellectual Disability, or Related Conditions Form [pdf]

Q: Facilities have been saying that according to the Medicaid Memo dated 11/19/18, they were only given temporary access to do level 1 screenings on current residents until 7/1/2019 & they could only do them for non-Medicaid eligible individuals. Is this true?

No. That was not the intent. The intent of the Memo was to alert nursing facilities of their responsibility to have procedures in place to assure completion of the PASRR process for anyone seeking admission who did not already have PASRR completed.

Q: So the hospital does not have to do the level 1 if the patient changes their mind and goes from home to NF after the screening has been successfully processed?

Once a LTSS Screening has been successful processed it becomes the responsibility of the NF to assure the PASRR Process is completed PRIOR to NF admission.

Q: We keep having facilities tell us that we must complete the level 1 screenings for patients who are not undergoing LTSS screenings. Can this be re-addressed from DMAS?

The local hospital or community-based screening teams should provide information to the NF and attempt handling it locally. Providing information to the NF's Director or

FREQUENTLY ASKED QUESTIONS: SCREENING CONNECTION CALLS

Medicaid LTSS Screening Assistance

Updated 4.1.2020

managers is often effective. If there are still issues please have the NF contact ScreeningAssistance@dmass.virginia.gov

DMAS has provided training and information sessions for NFs but not all have participated in these opportunities and not all NF staff responsible for admissions have attended these sessions.

AS SCREENING CONNECTION CALLS CONTINUE, THIS LIST OF QUESTIONS AND ANSWERS WILL BE UPDATED AND REPOSTED TO THE DMAS WEBSITE.

FOR FURTHER QUESTIONS OR CLARIFICATIONS PLEASE SUBMIT QUESTIONS MONTHLY DURING THE SCREENING CONNECTION CALLS OR VIA SCREENINGASSISTANCE@DMAS.VIRGINIA.GOV